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| W 000 | INITIAL COMMENTS<br><br>***Amended by IDR***<br><br>This report is the result of complaint surveys #3667471, #3687797, and #3695011 at Lakeland Village on 09/17/19, 10/02/19, 12/18/19, 12/19/19, 03/02/20, 03/03/20, 03/04/20, 03/05/20, and 03/06/20. Failed facility practice was identified and citations written.<br><br>These surveys were conducted by:<br><br>Patrice Perry<br><br>The survey team is from:<br><br>Department of Social & Health Services<br>Aging & Long Term Support Administration<br>Residential Care Services, ICF/IID Survey and Certification Program<br>PO Box 45600, MS: 45600<br>Olympia, WA 98504<br><br>Telephone: (360) 725-3215 | W 000 | | |
| W 127 | PROTECTION OF CLIENTS RIGHTS<br>CFR(s): 483.420(a)(5)<br><br>The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure two of two Sample Clients (Client #1 and Client #2) were protected from abuse when: | W 127 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| W 127 | Continued From page 1<br><br>1. Staff A, Attendant Counselor (AC), kicked Client #1 in the chest and rubbed a urine soaked sheet in his face.<br>2. The facility did not create a protection plan for Client #2 after she reported that she had a sexual relationship with a prior caregiver.<br><br>This failure resulted in Clients not living in a safe environment, free from abuse, neglect and mistreatment.<br><br>Findings included ...<br><br>1. Record review of Lakeland Village Work Procedure 10.6.C, dated 08/03/16, showed that kicking a Client was physical abuse.<br><br>Record review of Incident Report (IR) # 01-08312019, dated 08/31/19, showed that Staff A, AC, entered Client #1's bedroom as the Client was urinating on a bed sheet that was on the floor. After Staff A entered Client #1's bedroom, he kicked the Client in the chest, causing the Client to hit the wall behind him and then fall to the floor. A witness statement in the IR showed Staff A stated, "this will teach him not to do it again," then picked up the urine soaked sheet and rubbed it in Client #1's face.<br><br>Record review of Washington State Patrol Assault in the 4th Degree Investigative Report, Case No. [redacted], dated 11/08/19, showed Staff A, AC, kicked Client #1 on the chest, causing the Client to fall to the floor. Staff A then grabbed the urine soaked sheet, held it up to Client #1's face and said, "You don't do this." Staff A denied rubbing the sheet on the Client's | W 127 | | |

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| W 127 | Continued From page 2<br>face although he did state that he held the sheets up to the Client's face to "smell it, just to know what he did wrong and stuff." Staff A admitted to kicking the Client during the interview with Washington State Patrol investigators.<br><br>During an interview on 12/19/19 at 8:41 AM, Staff E, Compliance and Investigation Manager, stated that the investigation was complete. When asked if Staff A, AC, abused the Client, Staff E stated that the investigation determined that Staff A violated the facility's abuse prevention policy.<br><br>2. Record review of Complaint Resolution Unit (CRU) intake 3687797 showed that in January 2020, while in the presence of facility staff, Client #2 told her guardian that she had an inappropriate sexual relationship with her prior community caregiver (the Alleged Perpetrator (AP)), and he had been in contact with her. The facility contacted the CRU to report the allegation of the inappropriate sexual relationship.<br><br>Record review of a list of facility incidents, dated 03/02/20, for the months of January and February 2020, showed no incident listed for Client #2 for the allegation of an inappropriate sexual relationship with a prior caregiver.<br><br>During an interview on 03/02/20 at 11:23 AM, Staff K, Incident Coordinator, stated that the facility did not investigate the allegation but the facility did notify [redacted].<br><br>Review of Client #2's files on 03/04/20 showed no evidence of a protection plan for the Client if the AP attempted to contact or visit her. They showed no means of identification of the AP, | W 127 | | |

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| W 127 | Continued From page 3<br>what staff should do if the AP attempted to contact the Client, or what to do if the AP attempted to visit Client #2.<br><br>During interviews on 03/04/20 at 8:50 AM and 8:55 AM, and 03/05/20 at 5:42 PM and 5:52 PM, Direct Care Staff at the cottage where Client #2 lived, were asked if there were any restrictions on who could contact her or visit. All of the staff interviewed replied, "No," and stated that if restrictions were in place they would be available in her files.<br><br>During an interview on 03/05/20 at 4:32 PM, Staff R, Superintendent, stated that the facility was aware of the alleged inappropriate sexual relationship and Client #2 did not want the AP to visit. | W 127 | | |
| W 153 | STAFF TREATMENT OF CLIENTS<br>CFR(s): 483.420(d)(2)<br><br>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure one of one Sample Client's (Client #1) abuse allegation was immediately reported to facility administration after Staff A, Attendant Counselor (AC), kicked the Client in the chest and then rubbed a urine soaked sheet in his face. Staff B, AC, witnessed the abuse but did not immediately report the | W 153 | | |

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| W 153 | Continued From page 4 | W 153 | | |

incident to facility administration. Staff B waited almost four hours after the incident to report the abuse and to provide protection for Client #1 and any other Clients. This failure resulted in Client #1 waiting five hours to receive emotional support or a medical evaluation to determine the extent of his emotional and physical injuries, and left other Clients the Alleged Perpetrator (AP) encountered at risk for abuse.

Findings included ...

Record review of Incident Report (IR) # 01-08312019, dated 08/31/19, showed Staff B, AC, witnessed another staff kick Client #1 in the chest and rub a urine soaked sheet in his face on 08/31/19 at approximately 8:00 PM. The witness did not report the incident to the facility until 11:50 PM, 3 hours and 50 minutes after the assault occurred. There was no immediate plan to protect Clients from further abuse from the AP, identified as Staff A, AC. The AP continued to work with Clients until the end of the shift, approximately 2 hours and 30 minutes after the witnessed incident. The IR did not indicate why the witness did not report the assault to the facility upon witnessing it.

Record review of Client #1's Interdisciplinary Progress Notes, dated 09/01/19 at 5:00AM, showed a licensed nurse performed an assessment of Client #1's head, chest, and neurological (assessment to rule out potential brain injury) status, nine hours after the assault.

During an interview on 12/19/19 at 8:41 AM, Staff E, Compliance and Investigation Manager (CIM),

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| W 153 | Continued From page 5<br>stated that the investigation was complete and the staff that witnessed the abuse received retraining on the need to immediately reporting abuse. | W 153 | | |
| W 154 | STAFF TREATMENT OF CLIENTS<br>CFR(s): 483.420(d)(3)<br><br>The facility must have evidence that all alleged violations are thoroughly investigated.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to thoroughly investigate an incident of abuse for one of one Sample Clients (Client #1) after the Client was kicked by a staff member. The facility did not identify discrepancies within the investigation, and did not identify areas that required action to prevent potential recurrence. This failure prevented the facility from identifying and resolving discrepancies within the investigation, accurately summarizing the conclusions of the investigation, and recommending actions for safeguarding Client's safety.<br><br>Findings included ...<br><br>Lack of thoroughness<br><br>1. The facility did not interview the Attendant Counselor (AC) in charge to determine her knowledge of the incident<br><br>Record review of the 74/75 Cascade Daily Shift Exchange, dated 08/31/19, listed Staff G, AC, as the AC in charge of the evening shift. | W 154 | | |

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| W 154 | Continued From page 6<br>Record review of IR # 01-08312019, dated 08/31/19, showed the facility did not interview Staff G regarding the alleged abuse that occurred at the cottage while she was the supervising AC.<br><br>2. The facility did not identify that the facility does not have a specific process to ensure float staff (staff not routinely assigned to the cottage) had pertinent information for their assigned Client/s<br><br>Record review of IR # 01-08312019, dated 08/31/19, showed the 74/75 Cascade Daily Shift Exchange (a facility document listing which staff were assigned to care for which Clients), also dated 08/31/19, had eight staff scheduled to work evening shift at the cottage.<br><br>During an interview on 12/18/19 at 9:05 AM, Staff H, Acting AC Manager, stated that four of the eight staff scheduled for evening shift on 08/31/19 were not regularly scheduled staff at the cottage. Staff H stated that Staff B, Staff C, Staff D, and one additional staff were "float" staff and did not routinely work at the cottage.<br><br>Record review of Washington State Patrol Assault in the 4th Degree Investigative Report, Case No. [redacted] dated 11/08/19, showed Staff B, AC, assigned to provide care of supervision of Client #1 but he reported that he did not know what was "normal" for Client #1, referring to Client #1's behaviors.<br><br>During an interview on 12/18/19 at 2:00 PM, Staff I, prior Quality Assurance Director, stated that the cottages kept a binder with completed orientation sheets (verification they had the needed information to care for their assigned Client) for | W 154 | | |

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| W 154 | Continued From page 7<br>float staff. The Surveyor requested the 74/75 Cascade Cottage orientation book at that time.<br><br>During an interview on 12/18/19 at 2:20 PM, Staff J, Program Area Team Director, stated that there was no orientation paperwork for the four float staff for the evening shift at 74/75 Cascade Cottage for 08/31/19 to show they had the necessary information to provide the care and supervision needs of their assigned Clients.<br><br>3. The facility did not address staff phone use while supervising a Client<br><br>Record review of IR #01-08312019, dated 08/31/19, showed Staff D, AC, told the facility investigator that Staff B, AC, was "on his phone and continued to keep scrolling on his phone while Mr. [Client #1's last name] was in [sic] behavior." The IR did not identify the concern of staff being occupied on his phone rather than assisting his assigned Client.<br><br>4. The facility did not identify if a Client had the required supervision level followed<br><br>Record review of Incident Report (IR) # 01-08312019, dated 08/31/19, showed the Daily Shift Exchange for 74/75 Cascade Cottage had two staff members assigned to supervise and assist Client #1. The Client living in the bedroom next to Client #1 also had two staff members assigned to supervise him. The IR showed two staff sat outside of both of the Clients bedroom doors. The IR indicated that a staff assigned to the Client who lived in the bedroom next to Client #1 left his assigned post, entered Client #1's | W 154 | | |

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| W 154 | Continued From page 8<br>room and physically assaulted him. The IR did not indicate whether the Client's, who lived in the bedroom next to Client #1, required supervision was met when his assigned staff left him with only one staff to supervise him.<br><br>5. The Daily Shift Exchange sheet did not have the accurate staff assignment listed<br><br>Record review of 74/75 Cascade Cottage daily shift exchange, dated 08/31/19, showed Staff C, AC, and Staff D, AC, were assigned to provide care to Client #1 during the evening shift. Staff A, AC, and Staff B, AC, were assigned to care for another Client that lived in the bedroom next to Client #1's bedroom.<br><br>Record review of a witness statement, written by Staff D on 09/01/19 showed that he switched assignments partway through the shift with Staff B due to the behavior of the Client Staff B was assigned to care for.<br><br>6. The facility did not address that the Alleged Perpetrator talked with witnesses about the incident<br><br>Record review of Washington State Patrol Assault in the 4th Degree Investigative Report, Case No. [redacted], dated 11/08/19, showed Staff A, AC, admitted speaking with Staff C, AC, and Staff D, AC, about the incident after they were notified of being placed on alternate assignment related to the abuse allegation of Client #1.<br><br>Record review of IR # 01-08312019, dated 08/31/19, showed the facility did not address the | W 154 | | |

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| W 154 | Continued From page 9<br>issue of staff discussing the allegation of abuse during the investigation.<br><br>7. The facility did not address the issue that a Staff interview appeared rehearsed when interviewed regarding the incident.<br><br>Record review of IR # 01-08312019, dated 08/31/19, showed "It should be noted that Mr. [Staff C's last name] interview appeared rehearsed. When the discrepancies were pointed out to Mr. [Staff C's last name] he became a [sic] flustered and struggled to know what to say." The IR did not address the issue of the discrepancies and the fact that the interview appeared rehearsed.<br><br>8. The investigation did not identify where the facility abuse policy failed to determine appropriate preventative interventions for the prevention of abuse and the immediate reporting of abuse<br><br>Record review of Incident Report (IR) # 01-08312019, dated 08/31/19, showed Staff A, Attendant Counselor (AC), kicked Client #1. Staff B, AC, witnessed the event. The investigation did not identify why Staff A kicked the Client. The investigation did not identify why Staff B did not report the witnessed event immediately. Staff B waited approximately 3 hours and 50 minutes after the incident to notify the facility of the incident.<br><br>9. The facility did not identify that Staff C, AC, did not notify a supervisor that Client #1 urinated on his bed sheet, did not document the incident in the Client's file, and did not complete a Target | W 154 | | |

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| W 154 | Continued From page 10<br>Behavior Log (documentation of a behavior with factors that may contribute to the behavior and what actions staff implemented in response to the behavior.)<br><br>Record review of the of the 74/75 Cascade Daily Shift Exchange, dated 08/31/19, listed Staff G, AC, as the AC in charge of the evening shift.<br><br>Record review of IR # 01-08312019, dated 08/31/19, showed Client #1 lived at 74/75 Cascade Cottage and Client #1 urinated on his bed sheet. The IR did not contain an interview with Staff G, AC, related to the incident.<br><br>Record review of Client #1's Interdisciplinary Progress Notes, dated 08/31/19, showed Staff C did not document the incident of Client #1 urinating on his bed sheet after he removed it from the bed and put it on the floor.<br><br>Record review of Washington State Patrol Investigative Bureau Investigative Report Case No. [redacted], dated 11/08/19, showed that Staff C, AC, stated he documented Client #1's urination on the bed sheet in the Client's Behavior Tracking Log (TBL) on 08/31/19, the date of the incident.<br><br>On 12/18/19 a copy of Client #1's behavior log for 08/31/19 was requested from Staff L, Senior Secretary.<br><br>During an interview on 12/18/19 at 2:20 PM, Staff L, Senior Secretary, stated that the facility did not have any documentation on Client #1's behavior on 08/31/19. | W 154 | | |

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| W 154 | Continued From page 11<br>10. The facility did not identify that the bruising was not monitored/documented in Client #1's file<br>Record review of IR #01-08312019, dated 08/31/19, concluded that Staff A kicked Client #1 which caused bruising on Client #1's chest. There was no documentation that staff monitored the bruises on the chest after the incident. There was no description of the bruising, including the location, color, or extent.<br><br>Record review of Client #1's Interdisciplinary Progress Notes, dated 08/30/19 through 09/08/19, showed no documentation indicating that staff monitored the Client for physical injury to the chest after a staff member kicked him.<br><br>Record review of Client #1's Health Monitoring Flow Sheet, dated September 2019, showed Licensed Nurses were to monitor for latent injury, and document on the skin report every three days, alternating day shift and evening shift. The flow sheet contained initials, indicating the monitoring occurred however, there were no indications whether or not staff had identified latent injuries from the assault.<br><br>Discrepancies in statements and documentation<br><br>Record review of Client #1's Interdisciplinary Progress Notes, dated 08/31/19, showed Staff C, AC, documented that Client #1 sat at the kitchen table until 8:00 PM, then got his pajamas on and sat on his bedroom floor for a few minutes. At 8:45 PM, Client #1 crawled into his bed and was asleep at 9:00 PM.<br><br>Record review of Washington State Patrol | W 154 | | |

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| W 154 | Continued From page 12<br>Investigative Bureau Investigative Report Case No. [redacted], dated 11/08/19, showed staff reported that Staff A, AC, entered Client #1's bedroom at approximately 8:00 PM. Staff A, stated that he entered the Client's room at approximately 9:00 PM, not 8:00 PM as the other staff had reported.<br><br>Record review of a witness statement from Staff C, AC, showed he listed the incident time as 2:35 PM. The witness then wrote in the body of the witness statement that at approximately 8:05 PM Client #1 began making noise, moved his blankets to the floor and began urinating on them, almost 5 ½ hours after what he wrote as the "time of the incident."<br><br>Summary of conclusions<br><br>The facility did not determine if Client #1 suffered emotional harm related to the incident<br><br>Record review of IR # 01-08312019, dated 08/31/19, concluded that Staff A, AC, kicked Client #1, which caused bruising that lasted several days. The IR did not include documentation regarding the extent/location of the Client's injuries or whether the Client also experienced emotional trauma related to the assault.<br><br>During an interview on 12/19/19 at 8:41 AM, Staff E, Compliance and Investigation Manager (CIM), stated that the investigation was complete. Staff E stated that the Statewide Investigation Unit investigated incidents to determine whether staff violated facility policies but they did not identify | W 154 | | |

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| W 154 | Continued From page 13<br>other concerns or discrepancies found within the course of the investigation. Staff E stated that the facility was responsible for identifying and correcting any additional concerns within the completed investigation.<br><br>During an interview on 12/19/19 at 9:34 AM, Staff K, Incident Management Coordinator, stated that the facility signed off on the completed investigation on 12/10/19. | W 154 | | |
| W 157 | STAFF TREATMENT OF CLIENTS<br>CFR(s): 483.420(d)(4)<br><br>If the alleged violation is verified, appropriate corrective action must be taken.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to take corrective action when they did not implement their Plan of Correction (PoC) to prevent the recurrence of abuse for one of one Sample Clients (Client #1). This failure prevented staff from having a teaching plan and knowing how to respond to the inappropriate behavior of urinating in inappropriate places that Client #1 exhibited.<br><br>Findings included ...<br><br>Record review of facility Incident Report # 01-08312019, dated 08/31/19, showed the facility identified that a staff kicked Client #1 in the chest after the Client urinated on his own bed sheet.<br><br>Record review of a facility document, titled "Plan of Correction (5-Day Investigation)," dated 08/31/19, showed that the facility identified that | W 157 | | |

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| W 157 | Continued From page 14<br>the Client's Positive Behavior Support Plan (PBSP) did not identify or address the observed behavior of inappropriate urination. The facility tasked Staff F, Psychology Associate, with the responsibility of completing a functional assessment and updating the Client's PBSP. The facility listed the target date for completing the update to the PBSP as 09/30/19.<br><br>Record review of Client #1's PBSP, dated 12/02/19, showed the facility did not identify or provide training opportunities for staff and Client #1 related to the documented history of the Client urinating in inappropriate places, as the facility PoC instructed.<br><br>During an interview on 03/03/20 at 3:02 PM, Staff F, Psychology Associate, and Staff N, Lead Psychologist, stated that Client #1's PBSP was not updated after the incident. | W 157 | | |
| W 214 | INDIVIDUAL PROGRAM PLAN<br>CFR(s): 483.440(c)(3)(iii)<br><br>The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to assess and address an identified need for one of one Sample Clients (Client #1) when staff identified that Client #1 urinated on the bathroom floor, pulled his bedding off his bed, and urinated on it. This failure resulted in Client #1 not having training to teach him where to urinate, which could delay his move to a less restrictive environment. | W 214 | | |

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| W 214 | Continued From page 15<br><br>Findings included ...<br><br>Record review of Client #1's Individual Habilitation Plan (IHP), dated 04/24/19, showed Client #1 required staff supervision in the bathroom because he would urinate on the floor, play with it, and play in the toilet. The facility identified a goal of zero incidents of incontinence (involuntary loss of urine from the bladder) for three months in the IHP. The nursing care plan within the IHP indicated that the Client was able to hold his bladder but would attempt to urinate into containers to drink his urine, and played in the toilet after using it. The IHP did not identify urinating in inappropriate places as an identified behavior, or have any training to learn where to urinate.<br><br>Record review of facility Incident Report # 01-08312019, dated 08/31/19, showed Client #1 laid on his bed at 8:00 PM. Client #1 got up, removed his sheets from the bed and placed them on his bedroom floor. Client #1 then urinated on the bed sheets. Staff C, Attendant Counselor (AC), stated, "[Client #1's first name] pissed on his sheets again."<br><br>Record review of Client #1's Interdisciplinary Progress Notes, dated 09/04/19, showed Client #1 urinated on the floor of the bathroom. Staff instructed the Client to "stop" then helped the Client clean up the urine.<br><br>Record review of Client #1's Temporary Positive Behavior Support Plan (PBSP), undated, did not identify urinating in inappropriate places as an issue. There was no analysis of the behavior to | W 214 | | |

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| W 214 | Continued From page 16<br>identify if the Client chose to urinate on the floor, bedding, or containers or if the Client utilized whatever was available when he needed to urinate. There were no teaching/training supports, strategies for responding to, prevention of, or replacement behaviors for the documented behavior of urinating in inappropriate locations. The PBSP included "Wetting/Soiling Issues (Code #18)" but it did not include any training or instructions for the Client or staff to teach him where to empty his bladder.<br><br>During an interview on 01/08/20 at 1:03 PM, Staff F, Psychology Associate, stated that the facility did not complete a functional assessment of why Client #1 urinated in inappropriate places. When asked how a provider could differentiate if Client #1 was incontinent or if he intentionally urinated on items, Staff F stated that the facility would not necessarily differentiate between the two.<br><br>During an interview on 03/03/20 at 3:02 PM, Staff F, Psychology Associate, and Staff M, Lead Psychologist, stated that they were not aware of any instances of inappropriate urination since the implementation of the Behavior Management Plan. Staff F stated that Client #1 would attempt to urinate on staff if he was mad at them. He also stated that Client #1 would move to the community soon.<br><br>Record review of Client #1's Behavior Management Plan, undated, showed the facility identified "Wetting/Soiling Issues (Code #18)."<br><br>Record review of Client #1's Target Behavior Log (TBL) on 03/04/20 showed Code #18 occurred:<br>-January 13, 2020 urinated in his bedroom | W 214 | | |

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| W 214 | Continued From page 17<br>-January 25, 2020 urinated in his bedroom<br>-January 31, 2020 urinated inappropriately in bathroom<br>-February 5, 2020 urinated inappropriately in bathroom<br>-February 11, 2020 urinated in his bedroom<br>-February 14, 2020 urinated in his bedroom<br>-February 15, 2020 urinated inappropriately in bathroom<br>-February 18, 2020 urinated in his bedroom<br>-February 26, 2020 urinated in his bedroom | W 214 | | |
| W 242 | INDIVIDUAL PROGRAM PLAN<br>CFR(s): 483.440(c)(6)(iii)<br><br>The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to provide training to improve one of one Sample Client's (Client #1) toileting skills after they identified that the Client would urinate on floors, bedding, and himself. This failure resulted in Client #1 not learning appropriate toileting skills.<br><br>Findings included ...<br><br>Record review of Client #1's Individual Habilitation Plan (IHP), dated 04/24/19, showed | W 242 | | |

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| W 242 | Continued From page 18<br>Client #1 required staff supervision in the bathroom because he would urinate on the floor, play with the urine, and play in the toilet. The facility identified a goal of zero incidents of incontinence (involuntary loss of urine from the bladder) for three months in the IHP. The nursing care plan within the IHP indicated that the Client was continent (able to retain urine in his bladder) but would attempt to urinate into containers to drink his urine, and played in the toilet after using it. The IHP did not identify urinating in inappropriate places as an inappropriate behavior, or have any training to teach the Client where he should urinate. The IHP listed a future recommendation to teach Client #1 to learn to use the proper amount of toilet paper while toileting.<br><br>During an interview on 01/08/20 at 1:03 PM, Staff F, Psychology Associate, stated that Client #1 did not have training for toileting skills. | W 242 | | |
| W 253 | PROGRAM DOCUMENTATION<br>CFR(s): 483.440(e)(2)<br><br>The facility must document significant events that are related to the client's individual program plan and assessments.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to document a significant event in one of three Sample Clients' (Client #3) file after staff witnessed another staff push the Client and then aggressively pull him to a standing position. This failure prevented staff from having information necessary to monitor for potential physical and emotional trauma from the alleged | W 253 | | |

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| W 253 | Continued From page 19<br>abuse.<br><br>Findings included ...<br><br>Record review of Incident Report (IR) #01-02272020 showed that on 02/26/20 at 2:00 PM, a staff witnessed another staff (Alleged Perpetrator (AP)) push Client #3 into a dining room chair and then pull him to his feet by grabbing his left bicep and pulling him, forcing him to his feet. Client #3's shoe fell off under the table and staff did not allow him to retrieve it. The IR indicated the AP stated, "let's go have a little talk in your room." and the AP and another staff escorted Client #3 to his room. The AP did not return until the change in shift, approximately 30 minutes after the altercation. The IR did not indicate if the AP was alone with the Client during that time.<br><br>Record review of Client #3's Interdisciplinary Progress Notes, dated 02/26/20-03/04/20, showed no documentation of the incident that reportedly occurred on 02/26/20 at 2:00 PM. The staff assigned to Client #3 documented on 02/26/20 at 2:30 PM that the Client had a snack and sat at the table until change of shift. An entry dated 02/27/20 at 3:40 PM from a Psychology Associate showed an evaluation for psychological distress, without identifying why the Psychology Associate was completing the evaluation. The staff asked the Client how his day was and asked if anything eventful occurred and the Client replied, "No." There was no indication that the Psychology Associate asked about the incident on 02/26/20, the day prior to the assessment. There was no documentation that the Client was monitored related to the | W 253 | | |

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| W 253 | Continued From page 20<br>potential injury from being pushed or grabbed by the arm and pulled to a standing position.<br><br>During an interview on 03/04/20 at 10:20 AM, Staff Q, Attendant Counselor Manager, verified there was no Individual Habilitation Plan revision, Interdisciplinary Notes, or care plan in Client #3's file in relation to the reported incident on 02/26/20.<br><br>During an interview on 03/04/20 at 1:57 PM, Staff M, Registered Nurse 4, and Staff P, Developmental Disabilities Administrator 1, stated that it was unclear when the nursing department received notification of the incident and may not have been given enough detail to trigger a care plan to monitor for potential physical and emotional harm. | W 253 | | |
| W 331 | NURSING SERVICES<br>CFR(s): 483.460(c)<br><br>The facility must provide clients with nursing services in accordance with their needs.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to establish a plan of care for two of two Sample Clients (Client #1 and Client #3) when a staff member kicked Client #1 and a different staff member pushed Client #3 on to a chair. This failure resulted in the Clients not receiving assessments and potential treatment for injuries after staff abused them.<br><br>Findings included ...<br><br>Client #1 | W 331 | | |

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| W 331 | Continued From page 21<br>Record review of Incident Report (IR) #05920, dated 08/31/19, showed staff completed Client #1's nursing assessment at 1:00 AM on 09/01/19 after an allegation that a staff member kicked the Client in the chest, causing him to hit the wall. The body diagram on the assessment was blank. The nurse commented that there were no new injuries noted. There was no indication what skin injuries the Client had during the assessment so staff could compare injuries to their skin assessments to determine if the Client sustained injury from the assault.<br><br>Record review of Client #1's Nursing Assessment-Skin and Body Integrity form, dated 09/01/19, at 9:00 AM, showed Client #1 had multiple bruises, scratches, abrasions, and a reddened area on his torso, as well as both arms and legs. The assessment identified a bruise on the right side of Client #1's chest and a "newer bruise" on his left lower back. There was no indication which injuries could be the result of being kicked by the staff member.<br><br>Record review of Client #1's Health Monitoring Flow Sheets, dated September 2019, showed licensed nurses were to monitor for latent injury and document once a day.<br><br>Record review of Client #1's Interdisciplinary Progress Notes, dated 08/31/19-09/08/19 showed the facility did not document any monitoring of the bruises on Client #1's chest, back, and hip.<br><br>During an interview on 12/19/19 at 9:14 AM, Staff M, Registered Nurse, stated that Client #1 did not have a plan of care to monitor for bodily injuries | W 331 | | |

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| W 331 | Continued From page 22<br>related to the incident.<br><br>Client #3<br>Record review of IR #01-02272020 showed that on 02/26/20 a staff witnessed Staff O, Attendant Counselor, "shoved Mr. [Client #3's last name] back into the dining room chair aggressively." Staff O grabbed Client #3 "Harshly under the upper left bicep, then yanked up on Mr. [Client #3's last name] forcing him to his feet." Client #3 attempted to get his shoe that had fallen off during the altercation from under the table, but staff did not allow him. The IR showed a nurse completed a skin assessment on 02/27/20 with the identification of five injuries; a scratch on his stomach, a yellow bruise on his right shin, a small abrasion on his right shin, a round, light purple bruise on his left shin, and a blackened toenail on his 2nd toe of his right foot.<br><br>Review of Client #3's file showed no monitoring of Client #3 for potential injury related to the altercation on 02/26/20. An Interdisciplinary Progress Note, dated 02/27/20 at 3:40 PM, showed that a Psychology Associate evaluated Client #3 for potential psychological distress. It did not indicate what had occurred or what staff would monitor for, or report. The file did not contain a nursing care plan to monitor him for potential physical or psychological issues.<br><br>During an interview on 03/04/20 at 1:57 PM, Staff M, Registered Nurse 4, and Staff P, Developmental Disabilities Administrator 1, stated that staff monitored Client #3's skin but there was no documentation in his file related to potential physical injury or monitoring for potential psychosocial harm. | W 331 | | |

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| W 331 | Continued From page 23<br><br>Record review of Client #3's Skin report, dated 03/03/20, received via email on 03/06/20, showed nursing staff identified a minor injury to his big toe on his right foot, and on 03/05/20 identified a minor injury on back of his right thigh. There was no documentation related to how the injuries may have occurred to determine how the Client sustained the injuries. | W 331 | | |

Intermediate Care Facility: Lakeland Village
POC for SOD Date 03/06/2020 and Aspen Event ID# UJHC11

**Tag number**

W127

**CFR and title**

§483.420(a)(5) PROTECTION OF CLIENT RIGHTS

**Specific language from CFR**

The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment.

**Explain the process that lead to this deficiency.**

1. Staff A violated the facility's abuse prevention policy when he kicked Client #1 in the chest and rubbed a urine soaked sheet in his face.
2. When the reported allegation was received by the facility it had already been investigated by [redacted] and the allegation was found inconclusive. As the incident did not occur at the facility, and the alleged perpetrator was not a facility employee, normal protection protocols and investigation measures were not triggered to be implemented. This resulted in the facility not creating a protection plan for Client #2 after she reported that she had a sexual relationship with a prior caregiver.

**The plan correcting the specific deficiency.**

elated to Client #1

1. This incident was referred to Washington State Patrol for investigation.
   Person(s) Responsible: [redacted] CIMS
   Completed on: 9/6/2019
2. Staff A was terminated from employment at Lakeland Village.
   Person(s) Responsible: Connie Lambert-Eckel, Superintendent
   Completed by: 11/25/2019
3. All cottage staff who work on 74/75 Cascade received additional training in mandatory reporting, timeliness of reporting, and incident reporting.
   Person(s) Responsible: [redacted] Clinical Nurse Specialist
   Completed on: 3/6/2020

Related to Client #2

1. A directive was sent to all staff working with Client #2 that the prior caregiver is to not have contact with Client #2.
   Person(s) Responsible: Connie Lambert-Eckel, Superintendent
   Completed by: 3/5/2020

**The procedure for implementing the acceptable plan of correction for the specific deficiency cited.**

1. The facility will continue to train new staff on Mandatory Reporting, Incident Reporting and Investigations upon hire and provide annual training for all staff. This training includes scenario based competency evaluations with participants.
   Person(s) Responsible: [redacted] Clinical Nurse Specialist; Staff Development Department
2. All new staff working with Client #2 will be alerted to the directive that Client #2 is to not to have contact with the identified prior caregiver. All attempted contact by the prior caregiver will immediately be communicated to the resident's guardian, Superintendent, Attendant Counselor Manager, Habilitation Plan Administrator and Psychology Associate.
3. Facility employees will receive a directive to initiate an incident report for allegations that occurred outside the facility and include non-facility employed personnel. The facility will investigate the allegation to the extent authorized by outside authorities investigating the allegation. This investigation will include the development and implementation of all appropriate prevention plans.
   Person(s) Responsible: Brendan Arkoosh, ICF PAT Director
4. Facility employees who complete investigations will receive additional training on investigating the incidents identified in item three (3) above.
   Person Responsible: [redacted] Incident Management Coordinator

Superintendent — Title | [signature] — Signature | 4/3/20 — Date

**The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.**

All incident reports are routed to the Incident Management Coordinator to review the incident as well as to verify investigations are thorough. The Incident Management Coordinator will also review incidents and investigations to verify appropriate protection plans are in place and refer investigations to outside agencies if necessary. Any identified deficiencies will be immediately reported to the investigator and the ICF PAT Director for resolution.

HPAs and ACMs will complete routine observations on the living units to verify interactions between residents and staff are appropriate. Any identified concerns will be immediately addressed with the staff and reported as required.

**The title of the person or persons responsible for implementing the acceptable plan of correction**

Brendan Arkoosh, ICF PAT Director

**Dates when the corrective action will be completed.**

Lakeland Village will complete the corrective actions by May 1st, 2020.

**[POC CONTINUED ON NEXT PAGE]**

| **Tag number** |
|---|
| W153 |
| **CFR and title** |
| CFR(s): 483.420(d)(2) STAFF TREATMENT OF CLIENTS |
| **Specific language from CFR** |
| The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. |
| **Explain the process that lead to this deficiency.** |
| Staff B was a relatively new employee (less than three months) and the Washington State Patrol (WSP) report and interview with staff B indicated he was "frozen" and voiced concern that he would be blamed for the incident. This fear resulted in Staff B's delay in reporting his witnessing of an incident involving abuse of a resident. This delay in reporting left residents vulnerable to abuse from Staff A for the duration of the shift. |
| **The plan correcting the specific deficiency.** |
| 1. Involved staff received in-service training on mandatory reporting and timeliness of reporting.<br>Completed on: December 31st, 2019<br>2. All cottage staff who work on 74/75 Cascade received additional training in mandatory reporting, timeliness of reporting, and incident reporting.<br>Person(s) Responsible: [redacted] Clinical Nurse Specialist<br>Completed on: 3/6/2020 |
| **The procedure for implementing the acceptable plan of correction for the specific deficiency cited.** |
| 1. Mandatory reporting training conducted with Staff B on DDA policy 5.13.<br>Person(s) Responsible: [redacted] Residential Services Coordinator (RSC)<br>Completed by: September 1, 2019<br>2. Additional training on mandatory reporting and timeliness of reporting was conducted with Staff B.<br>Person(s) Responsible: [redacted] Clinical Nurse Specialist<br>Completed by: October 8, 2019<br>3. All staff receive annual training with regards to mandatory reporting, timeliness of reporting, incident reports, retaliation which is prohibited and that reporters are protected under whistleblower laws.<br>Person(s) Responsible: Area Supervisors |
| **The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.** |
| 1. Staff development maintains documentation for annual training as well as trainings completed while attending New Employee Orientation and notify Supervisors if training is not completed.<br>2. The Incident Management Coordinator will review all reported incidents of abuse, neglect, mistreatment to verify the incident was reported to the appropriate entities in a timely manner. Any delay in reporting will be immediately reported to the employee's supervisor and the ICF PAT Director for resolution. |
| **The title of the person or persons responsible for implementing the acceptable plan of correction** |
| Brendan Arkoosh, ICF PAT Director |
| **Dates when the corrective action will be completed.** |
| Lakeland Village will complete the corrective actions by May 1, 2020. |

**[POC CONTINUED ON NEXT PAGE]**

**Tag number**

W154

**CFR and title**

CFR(s): 483.420(d)(3) STAFF TREATMENT OF CLIENTS

**Specific language from CFR**

The facility must have evidence that all alleged violations are thoroughly investigated.

**Explain the process that lead to this deficiency.**

The facility investigators had established a practice of only interviewing staff involved in the incident or able to provide pertinent information with regards to the incident being investigated. This resulted in the facility not interviewing Staff G with regards to the cited incident as they did not have any direct knowledge of the incident as indicated by their witness statement.

The facility did not have a singular process to ensure staff that do not regularly work that cottage are oriented to provide the care and supervision needs of their assigned residents.

The focus of the investigation was on the alleged abuse toward Client #1. This resulted in the facility not directly identifying if the resident's supervision level was followed as it was identified in the investigation that the resident was asleep in his room during this event and still had a staff providing supervision outside his bedroom door per PBSP guidelines. This resulted in not clearly identifying that the alleged perpetrator had left his post assignment when the incident occurred. This also resulted in the facility not addressing that the alleged perpetrator talked with witnesses as the findings of the investigation indicated that the incident occurred and the alleged perpetrator's employment was subsequently terminated. This also resulted in the plan of correction for the investigation being focused on the findings and statements directly related to the allegation of abuse.

The facility has long been under the impression that [redacted] was the only entity authorized by the state of Washington to make findings of abuse or neglect as it relates to vulnerable adults. This resulted in the facility not clearly identifying in within the investigation its findings of emotional harm, a form of abuse, was likely to have occurred.

**The plan correcting the specific deficiency.**

1. The facility will develop a process to document the occurrence of staff switching posts within a shift.
   Person(s) Responsible: Brendan Arkoosh, ICF PAT Director
2. Facility ACM's will be trained on the process identified in #1 above.
   Person(s) Responsible: Brendan Arkoosh, ICF PAT Director; [redacted] Developmental Disabilities Administrator (DDA)
3. All staff will receive a directive about not using personal electronic devices while at work.
   Person(s) Responsible: Brendan Arkoosh, ICF PAT Director
4. The QA Department will evaluate the cottage orientation practices of all cottages. The QA department will then collaborate with area supervisors to establish a facility best practice.
   Person(s) Responsible: [redacted] IMC
5. A standardize cottage orientation practice for staff that have worked on a specific cottage for more than thirty (30) days will be developed and implemented.
   Person(s) Responsible: [redacted] DDA1
6. New procedure for Risk Assessment will be developed as a joint venture between the psychology and nursing departments to identify, assess and have plans in place to monitor resident reactions and coping for critical incidents.
   Person(s) Responsible: [redacted] Registered Nurse (RN) 4 [redacted] Licensed Psychologist
7. Procedure for Risk Assessment will include education for primary assessors for two branches of psychological distress to include: suicide/homicide/self-harm and abuse/neglect/mistreatment and exploitation.
   Person(s) Responsible: [redacted] Registered Nurse (RN) 4; [redacted] Licensed Psychologist
8. Nursing Acute Care Plan #10 for Psychosocial Distress will be updated to include specific monitoring of critical stress following potential abuse/neglect/mistreatment/exploitation for psychological and physical manifestations.

Person(s) Responsible: [redacted] Registered Nurse (RN) 4; [redacted] Licensed Psychologist

9. Nursing Acute Care Plan #13b for Self-harm will be updated to include specific monitoring of psychological and physical harm the resident may experience.
   Person(s) Responsible: [redacted] Registered Nurse (RN) 4

**The procedure for implementing the acceptable plan of correction for the specific deficiency cited.**

4. The facility will modify the current Daily Shift Exchange Log to include a section for switching posts while on-shift.
   Person(s) Responsible: [redacted] DDA1
5. ICF ACMs will receive in-service training on the updated form.
   Person(s) Responsible: [redacted] DDA1
6. ICF ACMs will in-service the updated form with their respective staff.
   Person(s) Responsible: Facility ACMs
7. A directive will be sent to all cottage ACMs outlining the cottage orientation expectations.
   Person(s) Responsible: [redacted] DDA1
8. ICF ACMs will in-service the updated form with their respective staff.
   Person(s) Responsible: Facility ACMs
9. The facility will develop a Risk Assessment procedure and screening tool to be utilized when a resident or group of residents experience or witness a critical incident. The procedure will outline the RHCs responsibility to develop an immediate protection plan, assess for injury or trauma, ongoing monitoring for latent stress responses and provide/refer treatment.
   Person(s) Responsible: [redacted] RN 4, [redacted] Psychologist 4
10. Risk Assessment procedure and screening tool to be reviewed by PMT for inclusion into Lakeland Village procedures.
    Person(s) Responsible: Brendan Arkoosh, PAT Director and [redacted] RN4
11. Psychology department staff will be trained on the screening tool and new procedure.
    Person(s) Responsible: [redacted] Psychologist 4
12. Nursing staff will be trained on the screening tool and new procedure.
    Person(s) Responsible: [redacted] RN4
13. Residential Service Coordinators (RSCs) will be trained on the screening tool and new procedure.
    Person(s) Responsible: [redacted] Attendant Counselor Manager (ACM)
14. Medical providers assigned to Lakeland Village will be trained on the screening tool and new procedure.
    Person(s) Responsible: [redacted] RN4 and [redacted] Licensed Psychologist
15. Designated direct care staff will be trained on the screening tool and new procedure.
    Person(s) Responsible: [redacted] RN4
16. The facility will update Acute Plan of Care (APOC) #10 to reflect the areas of concern regarding potential critical incident and ongoing monitoring of the resident for psychological distress.
    Person(s) Responsible: [redacted] Registered Nurse 4 (RN4), [redacted] Psychologist 4
17. Acute Care Plan #10 will be updated
18. RN3s will be trained on the updated APOC #10 and #13B
    Person(s) Responsible: [redacted] RN4
19. Nursing staff will be trained on the updated APOC #10 and #13B.
    Person(s) Responsible: Facility Nursing Supervisors
20. ACMs will receive in-service training on the updated APOC #10 and #13B.
    Person(s) Responsible: [redacted] RN4 and [redacted] Licensed Psychologist
21. Direct care staff will receive training on APOC 10.
    Person(s) Responsible: Area Supervisors
22. A directive to RSCs and RN3s regarding communication between disciplines for potential abuse/neglect was sent on March 31st, 2020. This directive included the need to document and inform cottage nurses of the nature of abuse/neglect/mistreatment/exploitation reported.
    Person(s) Responsible: [redacted] RN4
23. A directive was given to nursing staff on February 5th, 2020 regarding proper documentation and need for full body skin assessment to be completed for any suspected or reported abuse/neglect.
    Person(s) Responsible: [redacted] RN4

24. A job aid was created for nursing staff to properly stage and describe bruising including the approximate age of injuries noted. This was delivered to all ICF cottages on 2/23/2020.
Person(s) Responsible: [redacted] RN4

**The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.**

1. ACMs will provide a copy of all Daily Shift Exchange logs to the QA Department. The QA Department will review for any deficiencies and report any findings to the respective ACM for compliance. After the first week of reviews is completed, the QA Department will review a sample of varying sizes for three (3) months. Any identified deficiencies will be reported to the ACM and their supervisor for resolution. These reviews will continue in varying frequency and duration until sustainable compliance is evident.
2. ACMs will provide all cottage orientation logs to the QA department for one (1) month. The QA department will review the log for compliance with the updated procedure and provide feedback to the respective ACM if discrepancies are found. The QA department will randomly sample one (1) cottage orientation log from each cottage a month for the next 3 months to ensure on-going compliance.
3. The RN4 and Licensed Psychologist will review the first ten (10) completed Risk Assessment screenings to verify the Risk Assessment procedure is being implemented properly. Any identified deficiencies will be followed up with the employee completing the screening for resolution. After the initial review, the RN4 and Licensed Psychologist will review screenings for procedural compliance in varying frequency until sustainable compliance is evident.

**The title of the person or persons responsible for implementing the acceptable plan of correction**

[redacted] Quality Assurance Director

**Dates when the corrective action will be completed.**

Lakeland Village will complete the corrective actions by May 1, 2020

**[POC CONTINUED ON NEXT PAGE]**

**Tag number**

W-157

**CFR and title**

§483.420(d)(4) STAFF TREATMENT OF CLIENTS

**Specific language from CFR**

If the alleged violation is verified, appropriate corrective action must be taken.

**Explain the process that lead to this deficiency.**

When constructing the facility response to an investigation on a 16-202a (Plan of Correction) a responsible individual is assigned to complete a given task. The facility has not identified a formal process to inform, monitor and track responsible parties' progress toward completion of the task.

**The plan correcting the specific deficiency.**

1. The Psychology Associate will complete an assessment of Client #1's behavior of inappropriate urination.
   Person(s) Responsible: [redacted] Psychology Associate
2. Client #1's Interdisciplinary Team (IDT) will meet to discuss the completed assessment and associated recommendations.
   Person(s) Responsible: [redacted] Habilitation Plan Administrator (HPA)
3. The Psychology Associate will complete any necessary revisions or updates to Client #1's Behavior Management Plan (BMP) based on the completed assessment.
   Person(s) Responsible: [redacted] Psychology Associate.
4. Client #1's HPA will make any necessary revisions or updates to his Individual Habilitation Plan (IHP)
   Person(s) Responsible: [redacted] HPA

**The procedure for implementing the acceptable plan of correction for the specific deficiency cited.**

1. The facility will develop a formal process for assigning plan of correction items and verifying completion. This process will include:
   a. Notifying the employee responsible for completing a task identified and their supervisor, that the task is required to be complete and a required completion date,
   b. Establishing weekly reporting on plan of correction items by the employee's supervisor to the IMC until all actions have been verified as complete.

   Person(s) Responsible: [redacted] IMC

**The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.**

1. The IMC will provide a monthly report to the ICF PAT Director and area supervisors on the status of completion for tasks assigned in incident report plans of correction. Incomplete tasks will be identified and forwarded to the respective discipline's supervisor and responsible party. The ICF PAT Director, or their designee, will follow up with responsible employees and their supervisor for any identified deficits.

**The title of the person or persons responsible for implementing the acceptable plan of correction**

[redacted] IMC

**Dates when the corrective action will be completed.**

Lakeland Village will complete the corrective actions by May 1, 2020

**[POC CONTINUED ON NEXT PAGE]**

**Tag number**

W-214

**CFR and title**

§483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN

**Specific language from CFR**

The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs.

**Explain the process that lead to this deficiency.**

Lakeland Village previously used a system to analyze targeted behaviors that relied on a secondary employee inputting data collected on paper. This resulted in a delay in psychology associates being able to analyze data quickly and efficiently. This previous system also did not include a way to analyze qualitative data associated with the behavior. This resulted in new behaviors not being analyzed and necessary plan revisions not occurring in a timely manner.

**The plan correcting the specific deficiency.**

1. The Psychology Associate will complete an assessment of Client #1's behavior of inappropriate urination.
   Person(s) Responsible: [redacted] Psychology Associate
2. Client #1's Interdisciplinary Team (IDT) will meet to discuss the completed assessment and associated recommendations.
   Person(s) Responsible: [redacted] Habilitation Plan Administrator (HPA)
3. The Psychology Associate will complete any necessary revisions or updates to Client #1's Behavior Management Plan (BMP) based on the completed assessment.
   Person(s) Responsible: [redacted] Psychology Associate.
4. Client #1's HPA will make any necessary revisions or updates to his Individual Habilitation Plan (IHP)
   Person(s) Responsible: [redacted] HPA

**The procedure for implementing the acceptable plan of correction for the specific deficiency cited.**

1. Lakeland Village has developed an electronic data recording system, "Online Target Behavior Log (TBL)," to track and report residents' target behaviors. This new data recording system captures both qualitative and quantitative data. Data is collected by the staff member who witnessed the behavior and is immediately available to IDT members to analyze and review.
   Person(s) Responsible: Brendan Arkoosh, ICF PAT Director
2. The online TBL system was piloted on a single cottage to work out any systems issues prior to being implemented on all Lakeland Village's Intermediate Care Facility Cottages. This trial occurred from December 1st 2019 thru January 2020.
   Person(s) Responsible: Brendan Arkoosh, ICF PAT Director; Chris Ray, Psychology Associate
3. The online TBL system was implemented on all ICF Cottages on February 18th, 2020.
   Person(s) Responsible: Brendan Arkoosh, ICF PAT Director
4. The Psychology Associates will meet to identify and standardize reports within the online TBL system to allow for immediate review and analysis of data.
   Person(s) Responsible: Facility Psychology Associates; Brendan Arkoosh, ICF PAT Director; [redacted] Licensed Psychologist

**The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.**

1. Facility Psychology Associates will analyze the data within the online TBL system at least monthly, more frequently as indicated by resident need.
2. Facility HPA's will review the Psychology Associates reviews for each resident. HPAs will request any additional assessments by submitting a Requested Evaluation to the appropriate IDT member, schedule any necessary IDT meetings, or make any necessary IHP revisions based on the review.
3. The Quality Assurance Department will review the first completed review by each Psychology Associate using the new TBL system. Any identified deficit will be reported to the Psychology Associate and the HPA for correction.

**The title of the person or persons responsible for implementing the acceptable plan of correction**

Brendan Arkoosh, ICF PAT Director

**Dates when the corrective action will be completed.**

Lakeland Village will complete the corrective actions by May 1st, 2020.

**Tag number**

W-242

**CFR and title**

§483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN

**Specific language from CFR**

The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.

**Explain the process that lead to this deficiency.**

The goal identified in Client #1's IHP to have zero episodes of incontinence over a 3 month period was added to the IHP on July 30th, 2019. The IDT had determined to establish a baseline of these behaviors and began collecting data. From July 30th thru December 2019 there were 14 recorded incidents of this behavior, with a peak of eight (8) incidents in September and a low of zero documented incidents in November. This data was collected by hand and was included with other behavioral data. Lakeland Village previously used a system to analyze targeted behaviors that relied on a secondary employee inputting data collected on paper. This resulted in a delay in psychology associates being able to analyze data quickly and efficiently. This previous system also did not include a way to analyze qualitative data associated with the behavior. This resulted in Client #1's incontinence behavior not being analyzed timely as well as a delay in implementing any necessary plan revisions not occurring in a timely manner.

**The plan correcting the specific deficiency.**

1. Client #1's Behavior Management Plan was revised to include strategies for the identified behavior of inappropriate urination.
   Person(s) Responsible: [redacted] Psychology Associate
   Completed on: 12/29/2019
2. Client #1's HPA will facilitate the collaborative development and implementation of a formal program to increase his independence with toileting.
   Person(s) Responsible: [redacted] HPA
3. Facility HPAs will review resident's current IHPs to verify they include, for those residents who lack them, training in personal skills essential for privacy and independence. Facility HPAs will facilitate the collaborative development and implementation of training programs as identified from this review.
   Peron(s) Responsible: Facility HPAs

**The procedure for implementing the acceptable plan of correction for the specific deficiency cited.**

1. The Psychology Associates will meet to identify and standardize reports within the online TBL system to allow for immediate review and analysis of data.
   Person(s) Responsible: Facility Psychology Associates; Brendan Arkoosh, ICF PAT Director; [redacted] Licensed Psychologist
2. Facility HPAs will receive additional training in the regulatory requirements of W-242. This training will include analyzing resident assessments that pertain to this regulation and facilitating required training programs as indicated by assessment.
   Person(s) Responsible: [redacted] QAD
3. Lakeland Village has developed an electronic data recording system, "Online Target Behavior Log (TBL)," to track and report residents' target behaviors. This new data recording system captures both qualitative and quantitative data. Data is collected by the staff member who witnessed the behavior and is immediately available to IDT members to analyze and review.
   Person(s) Responsible: Brendan Arkoosh, ICF PAT Director
4. The online TBL system was piloted on a single cottage to work out any systems issues prior to being implemented on all Lakeland Village's Intermediate Care Facility Cottages. This trial occurred from December 1st 2019 thru January 2020.
   Person(s) Responsible: Brendan Arkoosh, ICF PAT Director; [redacted] Psychology Associate
5. The online TBL system was implemented on all ICF Cottages on February 18th, 2020.

Person(s) Responsible: Brendan Arkoosh, ICF PAT Director

**The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.**

1. Facility HPAs will submit their next completed IHP to the Developmental Disabilities Administrator to facilitate a review to verify the IHPs include, for those residents who lack them, training in personal skills essential for privacy and independence. Any identified deficits will be immediately reported back to the HPA for correction. Facility HPAs will continue to submit completed IHPs for review until sustainable compliance is evident in this area.
2. Facility Psychology Associates will analyze the data within the online TBL system at least monthly, more frequently as indicated by resident need.
3. Facility HPA's will review the Psychology Associates reviews for each resident. HPAs will request any additional assessments by submitting a Requested Evaluation to the appropriate IDT member, schedule any necessary IDT meetings, or make any necessary IHP revisions based on the review.
4. The Quality Assurance Department will review the first completed review by each Psychology Associate using the new TBL system. Any identified deficit will be reported to the Psychology Associate and the HPA for correction.

**The title of the person or persons responsible for implementing the acceptable plan of correction**

Brendan Arkoosh, ICF PAT Director

**Dates when the corrective action will be completed.**

Lakeland Village will complete the corrective actions by May 1st, 2020.

**[POC CONTINUED ON NEXT PAGE]**

**Tag number**

W-253

**CFR and title**

§483.440(e)(2) PROGRAM DOCUMENTATION

**Specific language from CFR**

The facility must document significant events that are related to the client's individual program plan and assessments.

**Explain the process that lead to this deficiency.**

For the purpose of maintaining anonymity during an investigation of abuse/neglect/mistreatment, details of the reported incident are protected. This has resulted in poor communication between disciplines at times and the lack of nursing completing appropriate assessments for injuries related to potential abuse or neglect. Care plans were not initiated to monitor for latent injuries.
No procedure existed that defined when a risk assessment of a resident is to be completed, which further contributed to the lack of appropriate monitoring via a care plan to occur.

**The plan correcting the specific deficiency.**

1. The cited incident has been documented in the identified resident's record.
   Person(s) Responsible: [redacted] ACM

**The procedure for implementing the acceptable plan of correction for the specific deficiency cited.**

1. The facility will develop a Risk Assessment procedure and screening tool to be utilized when a resident or group of residents experience or witness a critical incident. The procedure will outline the RHCs responsibility to develop an immediate protection plan, assess for injury or trauma, ongoing monitoring for latent stress responses and provide/refer treatment.
   Person(s) Responsible: [redacted] RN 4, [redacted] Psychologist 4
2. Risk Assessment procedure and screening tool to be reviewed by PMT for inclusion into Lakeland Village procedures.
   Person(s) Responsible: Brendan Arkoosh, PAT Director and [redacted] RN4
3. Psychology department staff will be trained on the screening tool and new procedure.
   Person(s) Responsible: [redacted] Psychologist 4
4. Nursing staff will be trained on the screening tool and new procedure.
   Person(s) Responsible: [redacted] RN4
5. Residential Service Coordinators (RSCs) will be trained on the screening tool and new procedure.
   Person(s) Responsible: [redacted] Attendant Counselor Manager (ACM)
6. Medical providers assigned to Lakeland Village will be trained on the screening tool and new procedure.
   Person(s) Responsible: [redacted] RN4 and [redacted] Licensed Psychologist
7. Designated direct care staff will be trained on the screening tool and new procedure.
   Person(s) Responsible: [redacted], RN4
8. The facility will update Acute Plan of Care (APOC) #10 to reflect the areas of concern regarding potential critical incident and ongoing monitoring of the resident for psychological distress.
   Person(s) Responsible: [redacted] Registered Nurse 4 (RN4), [redacted] Psychologist 4
9. Acute Care Plan #10 will be updated
10. RN3s will be trained on the updated APOC #10 and #13B
    Person(s) Responsible: [redacted] RN4
11. Nursing staff will be trained on the updated APOC #10 and #13B.
    Person(s) Responsible: Facility Nursing Supervisors
12. ACMs will receive in-service training on the updated APOC #10 and #13B.
    Person(s) Responsible: [redacted] RN4 and [redacted] Licensed Psychologist
13. Direct care staff will receive training on APOC 10.
    Person(s) Responsible: Area Supervisors

14. A directive to RSCs and RN3s regarding communication between disciplines for potential abuse/neglect was sent on March 31st, 2020. This directive included the need to document and inform cottage nurses of the nature of abuse/neglect/mistreatment/exploitation reported.
    Person(s) Responsible: [redacted] RN4
15. A directive was given to nursing staff on February 5th, 2020 regarding proper documentation and need for full body skin assessment to be completed for any suspected or reported abuse/neglect.
    Person(s) Responsible: [redacted] RN4
16. A job aid was created for nursing staff to properly stage and describe bruising including the approximate age of injuries noted. This was delivered to all ICF cottages on 2/23/2020.
    Person(s) Responsible: [redacted] RN4

**The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.**

The IMC will review all reported incidents of abuse, neglect, mistreatment to verify the incident was documented in the resident's record. Any deficit in documenting the incident in the resident's record will be immediately reported to the area manager and the ICF PAT Director for resolution

**The title of the person or persons responsible for implementing the acceptable plan of correction**

[redacted] Quality Assurance Director

**Dates when the corrective action will be completed.**

Lakeland Village will complete the corrective actions by May 1st, 2020.

**[POC CONTINUED ON NEXT PAGE]**

**Tag number**

W331

**CFR and title**

§483.460(c) NURSING SERVICES

**Specific language from CFR**

The facility must provide clients with nursing services in accordance with their needs.

**Explain the process that lead to this deficiency.**

For the purpose of maintaining anonymity during an investigation of abuse/neglect/mistreatment, details of the reported incident are protected. This has resulted in poor communication between disciplines at times and the lack of nursing completing appropriate assessments for injuries related to potential abuse or neglect. Care plans were not initiated to monitor for latent injuries.
No procedure existed that defined when a risk assessment of a resident is to be completed, which further contributed to the lack of appropriate monitoring via a care plan to occur.

**The plan correcting the specific deficiency.**

1. New procedure for Risk Assessment will be developed as a joint venture between the psychology and nursing departments to identify, assess and have plans in place to monitor resident reactions and coping for critical incidents.
   Person(s) Responsible: [redacted] Registered Nurse (RN) 4; [redacted] Licensed Psychologist
2. Procedure for Risk Assessment will include education for primary assessors for two branches of psychological distress to include: suicide/homicide/self-harm and abuse/neglect/mistreatment and exploitation.
   Person(s) Responsible: [redacted] Registered Nurse (RN) 4; [redacted] Licensed Psychologist
3. Nursing Acute Care Plan #10 for Psychosocial Distress will be updated to include specific monitoring of critical stress following potential abuse/neglect/mistreatment/exploitation for psychological and physical manifestations.
   Person(s) Responsible: [redacted] Registered Nurse (RN) 4; [redacted] Licensed Psychologist
4. Nursing Acute Care Plan #13b for Self-harm will be updated to include specific monitoring of psychological and physical harm the resident may experience.
   Person(s) Responsible: [redacted] Registered Nurse (RN) 4

**The procedure for implementing the acceptable plan of correction for the specific deficiency cited.**

17. The facility will develop a Risk Assessment procedure and screening tool to be utilized when a resident or group of residents experience or witness a critical incident. The procedure will outline the RHCs responsibility to develop an immediate protection plan, assess for injury or trauma, ongoing monitoring for latent stress responses and provide/refer treatment.
    Person(s) Responsible: [redacted] RN 4, [redacted] Psychologist 4
18. Risk Assessment procedure and screening tool to be reviewed by PMT for inclusion into Lakeland Village procedures.
    Person(s) Responsible: [redacted] PAT Director and [redacted] RN4
19. Psychology department staff will be trained on the screening tool and new procedure.
    Person(s) Responsible: [redacted] Psychologist 4
20. Nursing staff will be trained on the screening tool and new procedure.
    Person(s) Responsible: [redacted] RN4
21. Residential Service Coordinators (RSCs) will be trained on the screening tool and new procedure.
    Person(s) Responsible: [redacted] Attendant Counselor Manager (ACM)
22. Medical providers assigned to Lakeland Village will be trained on the screening tool and new procedure.
    Person(s) Responsible: [redacted] RN4 and [redacted] Licensed Psychologist
23. Designated direct care staff will be trained on the screening tool and new procedure.
    Person(s) Responsible: [redacted] RN4

24. The facility will update Acute Plan of Care (APOC) #10 to reflect the areas of concern regarding potential critical incident and ongoing monitoring of the resident for psychological distress.
    Person(s) Responsible: [redacted] Registered Nurse 4 (RN4), [redacted] Psychologist 4
25. Acute Care Plan #10 will be updated
26. RN3s will be trained on the updated APOC #10 and #13B
    Person(s) Responsible: [redacted] RN4
27. Nursing staff will be trained on the updated APOC #10 and #13B.
    Person(s) Responsible: Facility Nursing Supervisors
28. ACMs will receive in-service training on the updated APOC #10 and #13B.
    Person(s) Responsible: [redacted] RN4 and [redacted] Licensed Psychologist
29. Direct care staff will receive training on APOC 10.
    Person(s) Responsible: Area Supervisors
30. A directive to RSCs and RN3s regarding communication between disciplines for potential abuse/neglect was sent on March 31st, 2020. This directive included the need to document and inform cottage nurses of the nature of abuse/neglect/mistreatment/exploitation reported.
    Person(s) Responsible: [redacted] RN4
31. A directive was given to nursing staff on February 5th, 2020 regarding proper documentation and need for full body skin assessment to be completed for any suspected or reported abuse/neglect.
    Person(s) Responsible: [redacted] RN4
32. A job aid was created for nursing staff to properly stage and describe bruising including the approximate age of injuries noted. This was delivered to all ICF cottages on 2/23/2020.
    Person(s) Responsible: [redacted], RN4

**The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.**

1. The IMC will review all reported incidents of abuse, neglect, mistreatment to verify all necessary care plans were implemented in a timely manner. Any identified deficit will be reported the RN 4 for resolution.
2. The RN4 and Licensed Psychologist will review the first ten (10) completed Risk Assessment screenings to verify the Risk Assessment procedure is being implemented properly. Any identified deficiencies will be followed up with the employee completing the screening for resolution. After the initial review, the RN4 and Licensed Psychologist will review screenings for procedural compliance in varying frequency until sustainable compliance is evident.

**The title of the person or persons responsible for implementing the acceptable plan of correction**

[redacted] RN4 and [redacted] Psychologist 4

**Dates when the corrective action will be completed.**

Lakeland Village will complete the corrective actions by May 1st, 2020.